THE EFFECTS ON RESIDENTS' EXPERIENCE: THE VIEW OF THE SURGICAL RESIDENT*

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DURING MEDICAL SCHOOL I made a very difficult decision, one that took me months to make. I was going to become a surgeon. My decision was to *be* a surgeon, not to work as one, and whatever that involved was what I was going to do. "Surgeon" and "physician" are terms that define who I am, not what I do.

I frequently hear older physicians suggest that residencies are so much different today, that residents care only for shorter working hours and more leisure time, and that this represents a decrease in our commitment. They are mistaken. My fellow residents and I obviously are very committed to what we do, and to becoming the best physicians we can be, and I strongly resent some of the accusations I have heard that residents today are not as committed as those 20 or 30 years ago.

Dr. Barondess, president of the New York Academy of Medicine, suggests that there are three goals of residency training: development of technical competence, development of a humanitarian approach to medicine, and development of commitment to medicine and to patients. I would like to address each of these goals with respect to the 405 regulations and the subsequent discussions.

I doubt that the 405 regulations will really affect the development of technical competence. This may be surprising coming from a surgeon, but I think that the patients are out there, the cases are out there, and there should not be an adverse effect on developing the technical competence needed to be a physician or surgeon in the 1990s and on into the 21st century.

The second goal of residency training is to develop a humanitarian approach. Dr. Axelrod, the state Health Commissioner, laments loss of the

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physician-patient relationship in our high-tech society. One of his main concerns, with which I agree, is *who* is being trained to be our future physicians. I think this issue is extremely important but not necessarily one to be addressed during the residency. This is something that should be focused on prior to residency, something for the medical schools and even for premedical programs to address. I feel that compassion and humanity are not learned traits and that the mature decision to become a physician is made partly if not mostly because of a preexisting sense of humanity. We are not all strict scientists and I doubt that many strict scientists are entering medicine today. So there should be some approach, some addressing of this issue, but this needs to take place probably in the medical schools rather than in the residency programs. I wonder if all the focus and public debate on limiting residency hours and the setting of guidelines for structured hours and for structured leisure time sends a bad message to medical students and to premedical students. It casts doubt on our motivation and our commitment.

It is this third goal of training, the fostering of commitment, that is the goal most severely jeopardized by the 405 regulations. Dr. Preston Reynolds, a medical resident, raised the question of who are the people who supervise us, the residents, and whom we seek out for guidance in our treatment of patients. Every day, seven days a week I see my professors, my role models, by the bedsides of their patients, regardless of the events of the previous night. Regardless of the 3 A.M. emergency colectomy or whatever the case may be, they are there the next morning. They don't turn it off and they don't sign out. These are the people whom we ask to take care of our patients or our families when they are ill. The doctors who show us this commitment to their patients and commitment to scientific ideals are the people that we really look up to, and who we strive to be like when we are attending surgeons. I want to be the one who is looked up to for being there when my patient needs me, and I think that by limiting residents' hours we discourage the very behavior that demonstrates the commitment necessary to be an effective and respected attending physician.

One of the speakers discussed the quality of sleep. One of the studies suggested that a resident needs four hours of quality sleep a night and that seven hours of nonquality sleep is equal to that. I know I don't get quality sleep knowing that I haven't finished the job that I set out to do that day, and that my patients aren't well taken care of, and that I haven't followed up. I can't go home and get four hours of uninterrupted sleep that way. Dr. Marvin Lieberman, who coordinated this conference, met me when I arrived and said, "I didn't expect you to be here all day; I see they let you out." I thought

it interesting that he said this because our long hours are, for the most part, self-inflicted by our own sense of responsibility. It is not a matter of what we are being given permission to do, but of what we feel is necessary to give our patients the best care. So again I think that time should not be the focus of our discussions.

More important, the best thing that has come out of the discussions over the past couple of years has been the issue of supervision of residents. Nobody will argue that increased supervision of residents is a bad thing. We have all felt the positive aspects of being supervised by our attendings, and of having them a part of everyday patient care. From a surgeon's standpoint this sort of supervision is readily available. I stand across the table from one of my attendings for however many hours a day I am operating. This is one-on-one teaching across a narrow table. You don't get better teaching than that. At Mt. Sinai Hospital nothing had to change in terms of the surgery department. The policy there has always been that an attending scrubs on every case, service or not. When a patient comes to the Emergency Room without a private attending, he is seen initially by the Emergency Room physician, who is generally a senior resident. The admission is performed by another senior resident, who is in the house that night. The chief resident, who, if it is May 31, tomorrow will be an attending, must have a note on the chart within two hours of any admission to the surgical service. In addition, at the time of admission the attending will be phoned. If the attending has to come in, he will, but in any event there must be a note by the attending surgeon on the chart within 24 hours of the patient's admission. This policy was implemented before the 405 regulations. This sort of close supervision is both instructive and gratifying. This should be the main focus of our reforms in residency training.

Thus far, the main thrust of discussions and of actual legislation has been to limit the number of hours that a resident may work in one shift and in one week. Since the implementation of the 405 regulations 18 months ago, I have seen the quality of medical care suffer as a direct result. I do not need to discuss the issue of continuity of care, which has so obviously been affected. Another issue that some people have touched upon at this conference is that communication is such an important part of some of the problems in medicine. One cannot set guidelines on this but I think it is an important subject. Since the 405 regulations have been set, our department of medicine has a day float system. The resident who is on call at night is replaced in the morning by the day float. In our city hospital the resident who is on call goes home the next day and is covered by the people in the house. There is no day float. The

importance of adequate sign-out procedures is obvious, and has been discussed at this conference. I think interdepartmental communication, which has not been mentioned, is also extremely important, and this clearly is suffering. Frequently the people calling surgical consults are not the people who admitted the patients. I have gotten countless requests for the surgical department to see a patient, and when asked about the patient the consultor responds, "it was signed out to me that the patient needs a surgery consult." He may know the basic story, but he is not the one who was primarily responsible for bringing the patient in and working him up, and he is not the one who is the most intimately familiar with the patient's clinical course. I refuse to believe reports that patient care has improved when this sort of intra- and inter-departmental communication breakdown has occurred.

In conclusion, I think that legislation limiting residents' hours is a mistake. I think it definitely is detrimental to patient care. There is clearly a loss of continuity of care in the acute setting as well as the ambulatory care setting. I think this legislation sends a message to junior house staff and to future doctors that medicine is a job that can be worked in shifts like any other job, and I think that is a dangerous error. Dr. Petersdorf of the AAMC expects applications to internal medicine residencies may rise partly as a result of the limiting of residents' hours. I wonder if this is a good thing. I wonder if the kind of residents we are looking for are the ones who are responding to an offer of less work time. In addition, limiting our hours, as mentioned before, decreases our preparation for what it is that we are going to be doing as attendings. Our attendings are there all the time—they don't just sign out. When we have a sick patient we need to take care of the patient. I think that we should as physicians start young in fostering that sense of commitment and responsibility. Again, the reforms should focus on supervision and perhaps on decreasing nonphysician work performed by physicians. I think if we have the attending supervision and the ancillary support that we need, our patients will greatly benefit and we residents can work forever.